Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012450	A. BUILDING _____ B. WING _____	03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CENTRE LLC	611 E DOUGLAS RD STE 108 MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a preoccupancy survey. Facility Number: 012450 Survey Date: 03/22/2012 Surveyor: ReBecca Lair, LCSW Medical Surveyor The Centre LLC meets the requirements for Indiana State Licensure Rules 410 IAC 15-2.1 through 15-2.7 to admit and treat patients. QA: claughlin 03/29/12	S 000		